

THE CLINIQUE.

VOL. XVIII.]

CHICAGO, NOVEMBER 15, 1897.

[No. 11.]

Original Lectures.

HAHNEMANN AND HOMŒOPATHY.

EXTRACTS FROM THE GENERAL INTRODUCTORY LECTURE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL FOR THE SESSION OF 1897-98, BY A. K. CRAWFORD, M. D., SENIOR PROFESSOR OF THE THEORY AND PRACTICE OF MEDICINE.

In old Hebrew legendary lore it is told that the father of Abraham made his livelihood by making and selling idols. In the little shop there was always an assortment of grotesque images ranged on the shelves representing the various popular deities of the time. The God of Peace, the God of War, the God of Health and the God of Plagues, the God of Fire and the God of Destruction lived there in peace and harmony. But one day the father had to leave his home and he called unto him the boy Abraham to take care of the shop and the gods while he was absent. Left to his own devices, the boy Abraham looking about him saw that the God of Destruction held an ax in his hand. He forthwith took possession of this ax and proceeded to smash all the other idols in the shop.

The destroyer of idols invariably brings down upon his head the wrath of the worshipers, and no doubt, Abraham suffered the usual penalty. But later in life this same Abraham gave unto his people a greater and mightier God to worship. He turned a nation from idolatrous polytheism to a spiritual monotheism. The one great God of Israel which Abraham made them comprehend was more, ten thousand times over, than the multitude of Gods which their ancestors had worshiped.

About a century ago another Abraham appeared in the

world. An Abraham in the science of medicine. He also destroyed idols. He took the club from the hand of Esculapius and with it smote right and left the dogmas and beliefs of the medical world. Like Abraham of old the wrath of a sect fell upon his head and he has not even yet been forgiven for his act of destruction. He threw out of the practice of medicine the belief in polypharmacy, and gave the medical profession an almost perfected creed of spiritualized monopharmacy. For centuries the prescribers of medicine gave unto their long suffering patients gross doses of multitudinous drugs of such uncouth and nauseating sources that we wonder now how such things could be.

* * *

The world at large has not embraced Abraham's idea of divinity. The world of medicine has not accepted in full this new law of therapeutics. But the world of medicine has awakened sufficiently from its long centuries of hibernation to admit the fact that there is something better for mankind than the gross methods of Galen, and that there are many instances of what they are pleased to call the double action of remedies. They admit that ipecac will both cause and cure vomiting. They write it down plainly in their works that arsenic produces fatty degeneration, and that the same drug, in lessened doses, is the best remedy for the cure of that condition. They know that quinine will produce in a healthy person an ague, but still persist in the opinion that its action in quelling the fever and ague is not homœopathic.

These are mere samples out of the multitude of remedies and their application to disease which our friends of the old school have absorbed from homœopathic sources and adopted as standard prescriptions in their medical works. They have gotten no farther into the sunlight and warmth of a perfected therapeutic art than the bear has who crawls from his winter lair beholding a dismal chilly scene, but whose instinct tells him that the back of winter has been broken and genial spring will soon make the landscape joyous.

This old-bear school of medicine is gaunt and hungry for something better in the practice of the healing art. It snatches savagely at every green thing of promise that pokes its head through the unmelted snows. Its appetite is insatiable, because it has never yet been able to make a full meal out of all the patches of medical verdure which

have appeared. There is but one law of chemical affinity, there is but one law of gravitation, and there is but one law of therapeutics. Therefore so long as the old bear refuses to accept the universality of the homœopathic medical dogma in the application of remedies to disease, it will go about gaunt and hungry as ever, and wondering why the spring time does not advance.

The law of similars has been before them for one hundred years. The vast improvements which are noticeable in the old school practice in this single century are wholly due to the existence of the homœopathic principle which has been leavening its way constantly and increasingly into medicine. Modern medicine is a sort of a nondescript cub of the old bear. It has little resemblance to the parent that lived in centuries past. It imagines that it is, in the evolutionary sense, a higher development than its progenitors, maybe it is right. But after all it is only a bear.

The homœopathic law has been persistently denounced by the adherents of the old school without the study or understanding of what it is, but they will have abundant opportunity to reform their ways and to become good homœopaths, for truth cannot be obliterated. The same law of similars which was illustrated by Hahnemann 100 years ago will still be in evidence a thousand years hence.

A characteristic Scotchman who settled in Michigan in the early days became somewhat of a prominent figure in his community by virtue of the rapid settlement of the country about him. He was so constituted that when he knew he was right in regard to a matter, he could not understand how any one could disagree with him. One evening the family was much perturbed by the nonappearance of this methodical man at supper time. The meal progressed without him. Bedtime arrived and he had not come. The good wife waited up and wondered what had become of him. In the small hours of the morning she heard his heavy steps approaching the door. Meeting him with candle in hand she exclaimed: "Losh me! What's come o'er ye, John; where hae ye been?" John growled out: "I've been on the jury." "Yes, but what kept ye sae late?" "There were eleven obstinate deevils there, and it took me all the nicht to convert them!" If it takes us the night of many centuries these obstinate "deevils" must be converted.

*

*

*

For 1600 years the practice of medicine had been dominated by the example and writings of Galen. The greatest number of drugs, in the most grotesque confusion, compounded into one prescription seemed to be the aim and end of all pharmacy. The central idea seemed to be what quantities of drugs could a patient bear without killing him.

This was the condition of the "Practice of Physick" when Hahnemann was born in 1755, and such it remained long after the principles of homœopathy were made public by him in 1796. He was at this time a very busy man. He was smashing the idols of the various therapeutic systems then prevalent, and trying to enlighten the worshipers with the truths contained in the one he was endeavoring to found. Occasionally from out the babble of controversy and detraction which almost engulfed him, a voice would be heard like John's in the wilderness, coming spontaneously from one whose mind had caught the inspiration. So familiar a name in classical allopathy as Prof. Bristowe gave Hahnemann credit for what he did in these words, "that he had learning and ability and great reasoning power is abundantly clear. He saw through the prevalent therapeutic absurdities and impostures of the day. He laughed to scorn the complicated and loathsome nostrums which even at that time disgraced the pharmacopœias, and he exposed with no little skill and success the emptiness and worthlessness of the therapeutical systems which then prevailed."

A hundred years ago Hahnemann, his household and his writings comprised the whole homœopathic profession, journals, hospitals, dispensaries and societies. To-day, according to the *New York Medical Record*, the best known journal of the old school and noted for its conservatism, there are in the United States alone 143 homœopathic State societies, 112 homœopathic hospitals, 59 dispensaries, 35 homœopathic medical journals and 14,000 practitioners, graduates of twenty homœopathic colleges.

This is a very just statement, but it might be added that the very latest statistics show that there are additions to the figures given of 9 State societies, 18 hospitals, 3 dispensaries, and that we have 6 national medical organizations, one of which, the American Institute of Homœopathy, is the oldest national medical organization in America, older than the Allopathic American Medical Association; and that in one year we have added 510 graduates to the list of homœopathic practitioners.

It seems fitting that at the time Samuel Hahnemann promulgated his law of cure, the air should be full of revolution. Revolution in science, revolution in art, revolution in literature, and sanguinary political revolutions were rampant.

One hundred years ago navigation by steam was fermenting in the brains of boys, and neither railroads nor telegraphy had been dreamed of. Gas for lighting purposes had just been introduced but city streets were still unilluminated. It was the year of the discovery of lithography, the year that Jenner unfolded his theory of vaccination for small-pox. It was but a few months previous that Napoleon pointed his cannon down all the streets by which the Tuilleries could be reached, and mowed down the assailants with grape shot. The French Revolution was thus summarily brought to an end and the directorate established. Napoleon, that year, had just entered upon his dramatic career. The battles of the Pyramids, and of the Nile, Marengo, Austerlitz and Jena, Leipsic and Waterloo, were under the veil of futurity.

* * *

One hundred years ago there trod the earth such giants as Kant, Schiller, Goethe and Richter; William Herschel, Humboldt, Sir Humphrey Davy and Farady; James Watt and Robert Fulton; Beethoven and Hayden; Sir Walter Scott, Coleridge and Byron; Thorwaldson and Turner.

Another cluster can be grouped around that period, for we find that Carlyle, the philosopher, Prescott, the American historian, Thiers, the French statesman, Professor Morse, the telegrapher, Rossini and Myerbeer, the musicians were then in their swaddling clothes, but who, nevertheless, fulfilled nearly half a century of their existence and works contemporaneously with the founder of homœopathy.

In the midst of this glorious company of brainy men and while Europe was filled with the din of contending armies, the great therapeutic law, "*similia*," was being unfolded in a small town in Saxony by Samuel Hahnemann.

This man had received the highest education which Germany could give. In his student life he distinguished himself in all departments at the university. Like so many more who have attained fame in learning, the usual university course must needs be supplemented by arduous toil to enable him to keep at it. He was a master in languages, and translated tome after tome of valuable works

into the German tongue. His energy seemed practically exhaustless and his extra work was done while others slept. He was known among his fellows to be one of the first men of the day, not only in medical science, but in the collateral science of chemistry, and in that universal knowledge which comes from wide reading. It is rightly claimed for Hahnemann that his writings show a richness of medical knowledge which could have been surpassed by none and equaled by few men of his day. Hufeland, a contemporary of Samuel Hahnemann, pronounced him to be "one of the most distinguished German physicians."

* * *

This discovery was the great glory of Hahnemann's life. Drummond has written that "It is the very simplicity of the law which makes men stumble. For nothing is so invisible to most men as transparency." If the keystone of the science of homœopathy be graven from the formula of "like cures like" then there are but two other stones required to complete the arch. The one is that the knowledge of the action of drugs is to be obtained by experiment on the healthy human organism; and the other, that in the treatment of disease upon the principle of similars very small doses of medicine are most effective. Max Müller says "Nature's greatest works are achieved by her least forces, and man should be proud to imitate her example."

In support of the truth of these tenets all that can be said here is that in the United States alone 14,000 honorable and educated physicians are daily verifying them at the bedside, and 10,000,000 of the people are satisfied with the results.

Not all of 14,000 physicians practicing homœopathy in the United States are graduates of homœopathic schools. There are probably about 5,000 of this number reconstructed allopaths, those who have become tired of a pathy without a logic, who have deserted the Spanish lines and come over to the insurgents.

The men who thus come into the fold of the newer school of practice are of the broad gauge, liberal minded stamp and have had all the advantages and highest medical education which the old school could afford them. But the moment that they thus follow the dictates of their conscience and enter upon a practice which they believe to be for the better interests of their patients, they are at once ostracised by the school which graduated them, and their

names dropped from the rolls of the old school societies, and if not cut they are treated with cool courtesy by their life-long companions in medicine. The old bear still lives in the cub.

This very stringent course on the part of the dominant school holds many a lesser independent spirit from proclaiming his preference for the homœopathic method of treatment. Those who are graced with intrepidity sufficient to face this ordeal are I can well assure you, received with open arms and have extended to them the hand of fervent fellowship by the homœopathic fraternity, which in great degree mitigates the hardship of the severance of old ties.

The homœopathic school has no grave fault to find to-day with its recognition, status and progress in the United States. On the contrary, it has every reason to be thankful for words uttered and deeds done, often from unexpected sources.

In March of the present year *Life* published a somewhat comical article upon the appendicitis craze, defending the medicinal treatment pursued by well-known homœopaths. The concluding paragraph reads: "While not an advocate of any school *Life* is still unable to resist the belief that those who are really attached to their appendix, in any sense, will find the safest and most comfortable traveling on the homœopathic highway. All the guide-posts point in that direction."

* * *

To attempt a presentation of the growth and flourishing condition of all the homœopathic colleges and hospitals in America would take up too much time and would tire you because of the sheer monotony of the success which has been their portion. But I may be pardoned if I say a word about the "Old Hahnemann," of Chicago, because it is the institution with which I am most familiar, in which we are most interested, and which is the first college in this country to be named after the founder of homœopathy, Samuel Hahnemann. Chartered by a special act of the legislature of Illinois in 1855, it initiated its first course of lectures in 1860, in some rooms hired for the purpose, with a class of students which was outnumbered by the corps of teachers. Chicago had then a population of 112,172. To-day, in the heart of a city of nearly two million people, it conducts its work of preparing men and women for the medical profession in a series of buildings

of modern construction and equipment, consisting of a college with scientific laboratories and apparatus, a hospital with a capacity of 225 beds and a nurses' home, representing an investment of \$187,000. The endowments which have been made to the hospital amount to \$70,000 more, and in the thirty-seven years of its continuous and progressive existence it has conferred the degree of Doctor of Medicine upon 2,300 of its students, the largest number of graduates to the credit of any homœopathic college in the world.

Being desirous not to say anything objectionable in this address I have not applied the term allopath to our friends of another medical faith, because by their own declaration they are not allopaths.

I have refrained too, from calling them regulars, because I have too much regard for the strict definition of a word. And I now must ask their pardon for speaking of them as the old school, because their theories and therapeutics have changed as frequently and cheerfully, during this century, as the politics of a South American Republic. There is nothing in their armanent or literature which has stood the test of a hundred years. The only medical dogma in existence to-day which can claim a century run is the law of similars. Therefore we modestly claim that the only school of practice entitled to be called the "old school" is the homœopathic. What colors they are sailing under, or what kind of a boat they are sailing in in this year of grace is a matter one can merely conjecture.

Finally, in all reverence it may be claimed that the whole of Christendom has subscribed unconsciously to the homœopathic law. The creed of the Christian Church rests upon the words, "For as in Adam all die, even so in Christ shall all be made alive." "For since by man came death, by man came also the resurrection of the dead."

It is plainly upon the law of similars that the Christian's hope of salvation rests. A man, by his act, reduced the race and brought upon it a penalty. Another man, by his act, restored the race and brought condonement. Not the same man who destroyed built up again. Not identity, but similarity of men. Truly a homœopathic doctrine. And if the Ruler of a Universe, whose every deed is in accordance with law, saw fit to redeem a race by the employment of the law of similars, is it not possible that the founder of our creed of medicine "builded better than he knew?"

*THE TREATMENT OF GALLSTONES.**

BY GEORGE F. SHEARS, M. D., SENIOR PROFESSOR OF SURGERY
IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL,
CHICAGO.

PART II.

The treatment of gallstones includes first, the relief of the attack of pain; second, the removal of any stones already formed either in the gall bladder or its passages and third, the overcoming of the conditions predisposing to the formation of stones. This end may be obtained by a combination of hygienic and medical measures or by hygienic and surgical measures, but rarely by surgical measures alone. Where surgery is demanded for the removal of stones too large to be removed by other measures, both the beneficial influence of medicines and of general hygiene should be utilized in order that the perverted condition of the secretions which permits the formation of stones, may be changed and future formations prevented. For convenience I shall divide the treatment into medical and surgical but it must be remembered that the latter is always preceded, accompanied and followed by the former.

Medical treatment. Slight attacks of colic may be relieved by drinking large quantities of hot water containing ten to fifteen grains of sodium bicarbonate to the pint, and by applying hot fomentations to the abdomen. Belladonna, nux vomica, colocynth and calcarea carb. have been strongly recommended for the relief of spasmodic pain, and the first named, in the lower potencies has, I believe, been of service to me, but it is so difficult to determine the value of any remedy in the attacks because of their self-limiting character, that one cannot speak positively nor lay down any rules for their employment other than those indicated by their pathogenesis. In the severe attacks morphine is the only remedy that gives prompt relief. It may be administered subcutaneously in doses of one-sixth to one-quarter of a grain, and should be resorted to promptly. There is no more reason why a patient should be refused the relief and comfort afforded by this remedy during the dilatation of the duct by the passing stone, than that a patient should be denied the solace of chloroform during the dilatation of the sphincter ani. If morphine does not relieve, chloroform inhalation may be resorted to to relieve the distress temporarily.

*Continued from page 348.

The attack of colic having been relieved, means must be taken to remove the stones still in the gall bladder or ducts. Of the various remedies which have been advised as serviceable in the removal of stones, whether by increasing the flow of bile thus flushing the ducts, or by exerting a solvent action upon the stones themselves, nearly all have failed to accomplish the purpose. Indeed many of them, as experimental research has shown, have failed to dissolve stones immersed in them, or even to increase the flow of bile when administered in health. Thus calomel, euonymin, rhubarb, podophyllin, and benzoate of soda, it is said, diminish rather than increase the flow of bile, and many others have no effect except to produce intestinal peristalsis.

Notwithstanding the statement made by Goodno in his "Practice of Medicine," that olive oil, supposed by some to have a specific influence in this disease, is useless, I believe there is no other measure except a surgical one, which is so potent in the removal of gallstones. A large per cent of the cases, if the disease has not existed for too long a time, may I believe, be cured by this treatment, and I never advise operative measures unless this plan has failed after thorough trial, or the case is so critical that any delay is unwarranted. The plan, I know, is not a new one and is, in an indefinite way, the common knowledge of medical men but its persistent use is not so common, either because of the unpleasant character of the remedy, the difficulty many patients have in retaining the oil upon the stomach, or because of a lack of faith upon the part of the physician. In those cases in which the attack of pain is of short duration it may be given in doses of one-half ounce to one ounce, three times a day and continued for some months; in the more severe cases it may be increased in quantity and I have given as much as five or six ounces three times daily. It is not an uncommon thing for the patient to vomit the oil when first taken but after two or three trials the stomach becomes accustomed to it and retains it. It may be given plain, in hot milk, in seltzer water, with a little brandy and menthol, with lemon or any other way the ingenuity of the physician may devise. I have often been surprised to note, not only that the patient passed the gallstones easily as the result of this treatment, but that the emaciated patient often increased rapidly in flesh and improved in general health. In those cases in which the oil cannot be retained by the stomach

it may be administered as an enema. Eight to ten ounces may be given morning and night by means of a high rectal tube.

Did my time permit, I should be glad to read a record of cases successfully treated by this method. It would be interesting to pause for a moment and consider the probable explanation of the action of the oil in these cases. Touatre believes that the oil enters from the duodenum through the osteum duodenale of the common bile duct, into the biliary passages, and while a few uphold this theory, one of our members, Dr. Triem, claims to have found the oil in the gall bladder of a patient to whom it was administered and who died from heart failure shortly after its ingestion. Whatever may be its mode of action, the results are to my mind undoubted.

Together with the oil may be given china, nux vomica, chelidonium, calcarea carb., lycopodium, chionanthus or leptandrin as the general symptoms of the patient may indicate. Personally the positive statements of Dr. Thayer, of Boston, supported as they are by Allen, Hughes, Farrington and by prominent members of the institute, have led me to put my patients on china and to continue the remedy for several months, and as the results of this treatment have been good, I continue to use it.

If the patient is well nourished he should be advised to take active outdoor exercise, to drink freely of pure water and to take a simple but nutritious diet. If the patient be a woman she should be urged to remove all constriction about the waist and to arrange the clothing that the fullest opportunity for free respiration may be afforded. If the patient be nervous and weak he should be treated by absolute rest in bed. If these measures fail to relieve, operative measures should be resorted to. Mayo, Robson, Greig Smith, Jacobson, Naunym, Gumsprecht and others give a long list of conditions which indicate operative treatment, but it seems to me that the danger of an abdominal section is so slight if properly made, that in no case in which a diagnosis of gallstones can be positively made, and in which the medical and general treatment heretofore suggested has failed to relieve, or even in one in which such a diagnosis cannot be absolutely made, should a patient suffering from prolonged or paroxysmal pain in the region of the gall bladder, especially if accompanied by jaundice or symptoms of localized inflammation, be allowed to drift along into chronic invalidism or even death, with-

out having an exploratory incision made and the gall bladder and its passages examined. Distinct evidence of malignant disease forms the only exception to this statement, and even in such instances if gallstones are present, the operation may be made for temporary relief. No time should be lost in resorting to surgical measures when, after a thorough trial, medical and general measures have failed. The physician need not and should not wait until palpation demonstrates the presence of a tumor, or septic symptoms indicate empyema as a complication. As with strangulated hernia, it is not the operation which kills but the physician who delays until inflammation supervenes and serious complications arise.

Surgical treatment. A more exhaustive review of the different surgical procedures than time now permits may be found in the various text-books and I shall not attempt to compete with these works but shall briefly state my own practice and thus emphasize what I consider the best surgical procedures.

Unless other conditions contra-indicate, I open the abdomen by a vertical incision in the right semilunaris. If this does not give enough working room, or if the stone is in the common duct and the duct at its entrance into the duodenum is not readily accessible, the incision is extended by making a transverse cut from the upper end of the first incision, across the fibres of the rectus muscle. The gall bladder is then found, examined and if it contains a stone, is pulled up into the incision, and surrounded by gauze and the stone removed. If much distended it is first aspirated and then incised. I have used various instruments for effecting the removal of the stones, such as forceps, scoops, and so forth, but have found the fingers more effective than anything else. The sac is held up firmly with one hand, while with the other the duct and the gall bladder are milked upward, the stones being pushed along by a succession of squeezes. This method is less liable to injure the walls of the passages than hunting around in the gall bladder with forceps, and avoids the danger of pushing the stones down into the cystic or the common duct, an accident which is not infrequent. If the gall bladder is normal in appearance, if the patient has had no jaundice and if the ducts are patulous, immediate closure is made by two rows of stitches, the gall bladder is dropped back into the abdomen and the wound is closed without drainage. This is ideal cholecystotomy, and any one who has made

this operation successfully and has also made the ordinary operation of suturing the gall bladder to the skin and maintaining a biliary fistula, will always prefer the former to the latter. When the operation is thus made the recovery is rapid, adhesions are avoided, traction on the gall bladder is not made, a biliary fistula is dispensed with and the dangers of abdominal hernia are lessened. This last is not an unimportant item, for although the downward pressure of the abdominal viscera tends to produce hernia in the lower part of the abdomen rather than in the upper, still the frequency of umbilical hernia demonstrates that the upper abdomen is not exempt. Indeed, one of the worst abdominal hernias which I have been called upon to treat followed the breaking down of the tissues of upper third of the right semilunaris.

The operator must, however, be sure of the patulence of the duct before he assumes the responsibility of this operation of primary return and immediate closure of the abdomen. If the gall bladder is very large and distended or much thickened, or if there is evidence of empyema, after incision of the bladder, removal of the stones and thorough cleansing, the gall bladder is united, not to the skin but to the peritoneum and to the fibrous sheath of the muscle. This leaves a space between the opening into the gall bladder and the skin which readily granulates and renders subsequent closure easier. It will be noted that I make the operation at one sitting instead of two as often recommended. It is very difficult to determine the condition of the walls and the nature of the contents of a tensely filled gall bladder when unopened, while if it is opened the interior and exterior may be thoroughly examined at the same time by the combined touch. When the operation is made at two sittings all examination is limited to external manipulation of the sac at the first sitting or examination by means of a probe after the production of a fistula. The great dread of infection resulting from the bile coming in contact with the peritoneum, is, I believe, unwarranted. From my own observations I do not believe normal bile to be septic and I have no fear that it will infect the peritoneum by simply coming in contact with it. If, however, the contents of the gall bladder are purulent the operation made at two sittings is unquestionably safer.

If the stone is impacted in the cystic or the common duct, the wound is enlarged as suggested, the duct incised,

the stone removed and the incision closed with silk sutures. In the performance of this, often a difficult procedure, I have used with profit the suggestion of Elliot in the "Annals of Surgery," 1895, the use of the inverted Trendelenberg position and the incision of the duct before the removal of the stone. The technique is as follows: The patient is placed on an inclined plane at an angle of a little less than forty-five degrees, being supported by straps under the arm, a sand bag being placed under the back. In this position the intestines gravitate to the lower part of the abdomen and when the liver is held up the working space is much increased. The stone having been found and grasped between the thumb and finger, the duct is brought as near the surface as possible. The duct wall is then incised over the stone and the Lembert stitches are then placed over the stone before it is extracted. This expedient overcomes the difficulty of suturing a collapsed duct, gives a better hold and at the same time enables the operator to promptly close the opening and limit the discharge of bile. I have no doubt the abdominal wound might be closed without drainage, but having less confidence in my technique because of the depth of the wound, I have not dared to do this, but have passed a small glass drainage tube, surrounded with gauze, down to the incision in the duct. If the duct cannot be raised to place the sutures, the opening is tamponed with gauze and drained. While such a procedure does not give as good results as immediate suture, I know from one case under my charge, that it does not prevent satisfactory recovery. The plan of attempting to crush the stone with padded forceps or to break it by needling I have never practiced, believing the dangers of an incomplete operation or the dangers of inflammation to be greater than by simple incision and suture.

In several cases I have been unable to find stones either in the gall bladder or in the ducts. In such cases as well as in those where there is occlusion of the ducts from malignant disease or other causes, I have tried the making of an external fistula and also the making of a primary cholecystenterostomy and am much in favor of the latter method, believing that the drainage thus obtained will cure those cases in which the occlusion is due to mucous engorgement, without subsequent operation, and in cases of permanent occlusion the condition is unquestionably better after this operation than it could be with a biliary

fistula. Some surgeons would lead us to believe that a biliary fistula closes of its own accord or is easily closed when the duct becomes patulous. This does not accord with my observation. It sometimes remains open and resists the best directed efforts at closure. Neither do I believe that a permanent fistula is a matter of small moment, in those cases where the ducts are permanently occluded. My observation is that the condition is insufferable and that the patient will risk anything to have it cured. A secondary cholecystenterostomy after adhesions have formed and where an external biliary fistula exists, is often a matter of great difficulty, as I have several times demonstrated. In making this operation I use the Murphy button, and in such cases it is certainly a most useful and successful device.

In none of these procedures do I claim originality, but in joining hands with the few who advocate, in suitable cases, immediate closure of the gall bladder, I believe I am adopting a procedure which is as pronounced a step forward from the formation of a biliary fistula, as the ligating and dropping back of the pedicle in ovariectomy is from the old clamp extra-peritoneal method, and in advising primary cholecystenterostomy in occlusion of the cystic or common duct, whether due to inflammatory or to malignant disease, I believe I am advocating a practice which lessens the inconveniences and the dangers of a most distressing condition.

*RAYNAUD'S DISEASE. ILLUSTRATED BY A
CASE.*

BY H. V. HALBERT, M. D., PROFESSOR OF THEORY AND PRACTICE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, CHICAGO.

Raynaud's disease is comparatively rare, and its pathology is not accurately settled. In all probability it is a neurosis. By some it is called an acro-neurosis, inasmuch as its symptomatology relates to the extremities. Symmetrical angio-neurotic gangrene is a better term, as it defines more clearly the existing status. There is also an abortive form, known as *digiti mortui*, which resembles the true disease but has not much pathological significance.

The etiology does not point to any particular age or

class of subjects. It was supposed for a time to be more natural to women, but that is not statistically confirmed. Anæmia and chlorosis are prominent factors, and malaria and infectious fevers are associated with its history. That it is related to nervous debility is seen from the fact that it almost always attends reflex nervous disorders; there are also frequently present signs of cord perversion, which if not shown by pronounced lesions, are at least connected with trophic deficiency. Again, a local neuritis may be primarily or secondarily related to its appearance, and many times there is a history of an obliterating endarteritis. An oversensitive nervous system, shock, hysteria or functional nervous derangement may be found in nearly every case. This directs our attention to the neurological phase of the disease, and from this standpoint we must regard our treatment. The nerve centres may be irritated by an impoverished condition of the blood, by the poison of malaria or toxic agents; any of these may cause spasm of the peripheral nerves, showing a vasomotor affection, which is our only solution of the pathology.

The disease shows its symptomatology suddenly, though a careful examination of the patient will reveal a cause of long standing. The fact that it is so closely associated with anæmia and chlorosis would explain its frequency with women. The debility and toxic possibility entailed by confinement and the parturient condition would be sufficient to create it; in all cases we can look back to a period when the nervous system has been ravished by a wasting disease of some kind. Often it is characterized by an undue coldness, numbness or waxy color of certain parts of the extremities. The fingers and toes are most often involved. This may vary from a condition which resembles frost bite to a gangrenous appearance with the definite lines of demarcation. Sensory symptoms may be abolished in severe cases, so that pain is gone as much as in leprosy. It is therefore often spoken of as local asphyxia or local syncope. This condition may extend to gangrenous disintegration where hæmaturia is pronounced.

These severe symptoms generally relax until the parts regain their normal condition when it is liable to recur. As a general thing, however, the tendency is toward recovery though it may be a long time before the cure is permanent.

And now what shall we say of the pathology? To find

a definite lesion of the cord that would account for the systematic gangrene of the extremities like this would be a difficult task indeed; it would be almost impossible for a pronounced central lesion not to show degenerative disorder nearer the cord; and if it were entirely peripheral then we should see some local cause for it, which is not generally the case. It seems then quite clear that we must regard it as a general cord neurosis in which the vasomotor system is at fault. As it occurs in connection with conditions of debility or systemic toxic invasion we may be sure that there is a state of extreme shock to the cord cells which control trophism; when this exists the vaso dilators are first stimulated and finally paralyzed so that blood which has gravitated suddenly to the extremities is held there until it is a morbid factor itself; then the peripheral peristalsis is shut off until venous stasis and arterial deficiency starve the parts. But back of this there exists a general paralysis of the peristaltic action in the larger arteries; this causes a decided innervation of the whole nervous energy and a consequent depletion of the circulatory system. This alone is sufficient to create the symptoms of the disease, but just why it is so systematically limited to the fingers and toes is yet an unsettled question. Morvan's disease has the greatest similarity, but this is associated with conditions of central cord degeneration which cannot be denied. In all probability Raynaud's disease will continue to mystify the pathologists but we have fortunately the symptoms left to guide us, in our treatment, which are all important.

Case. The case which I wish to use as an illustration is a woman, forty three years of age, German in nationality, who, until the appearance of this affliction, was apparently well. Two years ago she noticed a sudden loss of her general health without any known cause. Her husband had recently died of pulmonary tuberculosis, and she charged her failing health to the exacting care of him during his illness; she felt and appeared as if she had been poisoned as she claimed; exhaustion, loss of flesh, a waxy color of the integument, and a weakness of mental capacity troubled her most. Sometimes she would have chills, and again she would be bothered with paræsthesia, alternating with hot and cold spells; her menstrual, digestive and other functions seemed normal, but the terrible exhaustion continued. The urinalysis and blood examinations revealed little abnormal and her power of locomotion

showed no change; there were, however, some signs of tachycardia showing sympathetic irritation; otherwise no cause could be found for this terrible exhaustion and increasing emaciation. Suddenly a coldness involved the hands and toes; no external heat relieved them and very soon the parts began to look purple; later watery blebs appeared, sensation decreased and some motor paralysis was present. A few months after a definite line of demarcation was noticed, and from that time on the change advanced almost to the border land of gangrene.

When my first examination was made I almost advised the services of a surgeon for I feared amputation would be necessary. It then appeared to me that it was a case of neurosis and entirely amenable to internal medicine. After further study I decided upon ferrum phos. as my remedy, and for these reasons: According to Farrington, we learn that in its proving it produces a sort of semi-paralytic condition in which the blood vessels become dilated. This is entirely in accord with my theory of the vaso-motor disturbance in the pathology of the disease. Then again we know that the pulse which calls for this remedy is of a full, soft character, such as is seen in no other remedy; that of the patient answered to this description accurately. Furthermore, the remedy refers to that form of congestion in which there is no pronounced hemorrhage but a slight tendency to it in which the discharges are "streaked with blood;" this is because the loss of systemic energy and the circulatory debility do not permit a copious loss of blood. Our patient was constantly complaining of slight bloody discharges at various times from the nares, the bowels and the uterus. In the ferrum phos. patient there is a lack of iron in the smaller blood vessels; a proportionate amount of iron in the blood is necessary for the conveyance of oxygen; when this is deficient in the circulation it is drawn from the periphery to the deeper organs for the maintenance of the vital principle; thus it is anæmia exists, and this was the pronounced symptom in our patient. This condition of anæmia had existed long enough to deprive the nerve centres of their own nourishment and that necessary for their innervating power. This accounted for her peculiar sensory symptoms and the weakness of motor action. In the same way it accounted for an impoverishment of the skin and a consequent tendency to small boils of which she complained constantly. In like manner it explained the frequent recurrence of in-

termittent fever, for the insomnia from the relaxation of the muscular fibres in the walls of the cerebral blood vessels, and the general depletion of circulation which culminated in the apparent death of the parts farthest from the heart's influence.

The combination of phosphorus with iron in this preparation makes it doubly valuable where the tissue depletion is dependent upon nervous debility. Hence we may account for the remarkable result in this case. You will see to-day that there are no outward signs of discoloration such as were noticed when the case first came before us. Yet if you look carefully you will still see the outline of the demarcation where nature might have amputated the parts and the fingers are still somewhat swollen and cold to the touch.

The patient has been given the 6th decimal potency of this remedy for several months. It is the only remedy she has had, and it is bearing out not only our pathological theory but it is curing what is generally supposed to be an incurable disease. If anything teaches us the efficacy of a tissue remedy this case ought to do it, and moreover, it should convince us that severe cases will respond to the homœopathic remedy when extreme medication gives no result. Iron in heroic doses would surely impede the progress of a case like this, but when it is administered in doses sufficient for chemical absorption, our results will confirm a hope when disease is supposed to be master.

I hope to show you, as time goes on, that this woman will have ample confidence in a perfect recovery.

Clinical Society Transactions.

CORNELIA S. STETTLER, M. D., CORRESPONDING SECRETARY.

ORRIN L. SMITH, M. D., RECORDING SECRETARY.

SEPTEMBER MEETING, 1897.

The regular monthly meeting of the society was held in the Hahnemann College amphitheatre, September 25, at 8:30 P. M., President Crawford in the chair.

REPORT OF THE SECTION ON DISEASES OF THE THROAT AND NOSE.

ORRIN L. SMITH, M. D., CHAIRMAN.

LV. FOREIGN BODIES IN THE NOSE AND MOUTH. BY DR. FILIP A. FORSBECK, OF MILWAUKEE.—This is a timeworn subject, which has been so thoroughly explained by the teachings in our text-books, that nothing new can be offered in the way of remedial measures. One need simply reiterate and practice the maxim of long ago, "*tolle causam*," and the morbid manifestations will cease in consequence. But we find in some cases of less recent standing that the original cause has been lost sight of and a prescription for "*nasal catarrh*" or other ailments, equally as common, is not seldom given, based upon a hasty examination or faulty diagnosis.

In children, we might in all cases of irritation and inflammation of these orifices, first suspect and search for foreign bodies. "Presence of mind and absence of body" might be a good adage, well worthy to be remembered by those who have children in their care.

Cases of longer standing, in which the "*catarrh*" has no tendency to "*letting up*" are finally referred to the family physician or specialist. And this is where many a specialist has covered himself with glory and earned a great reputation for "*wonderful cures*." But these cures are only interesting to the medical mind in the measure as the foreign bodies are out of the ordinary, or in the degree and character of the accompanying symptoms.

Following are three cases which have come under my observation, which may be added to the clinical record of foreign bodies in the nose and mouth, and serve to illustrate what may be expected in this kind of cases:

NASAL CATARRH FROM THE PRESENCE OF A STRAW.—*Case 1.* Sam S., boy six years, had long been suffering from catarrhal discharge of the nose, especially of the left side, excoriating the mucous surfaces, making the nasal cavities raw and angry looking; nasal respiration obstructed; the sense of smell totally obliterated and the voice changed. The nose was swollen and tender and bled occasionally. The little fellow had been subjected to sprays, nasal snuffs, bathing, hot air and internal remedies, gratuitously offered by well meaning neighbors, but with no avail.

Having cleansed the nasal passages with a spray, I inspected them by means of strong reflected light and with a small electric light introduced in one nostril, thus illuminating the opposite one in a satisfactory manner. Without any difficulty I removed with the forceps a straw, incrustated with the calcareous salts of the secretion. The bleeding that followed was readily controlled by styptic cotton and in a few days the little patient was discharged cured.

NASAL CATARRH FROM A BIT OF SPONGE.—*Case 2.* Boy six years, in a local orphan asylum. This case presented a very similar set of symptoms, and I was at first deceived as to the real nature of the difficulty. Accidentally one day, while making some local application in the nose, I was agreeably surprised at finding a piece of sponge attached to the forceps. It was quite small, but sufficient to keep up for weeks an inflammatory focus. The child recovered very readily.

TOOTHACHE AND ALVEOLAR MISCHIEF FROM A CURIOUS FOREIGN BODY. *Case 3.* A boy about five years, had suffered for several days from toothache, and the gums were swollen and very painful to the touch. A little chloroform was administered and opening the oral cavity, I found on the last molar a covering resembling a metal crown of a tooth, which upon closer examination proved to be a cap of one of the keys on his father's accordion, which had fitted itself to the tooth and with its edges burrowed down into the gums, making them sore and bleeding. One might

be tempted to ask if this case in any way verifies the supposition that the musical proclivities or peculiarities of a father are sometimes transmitted to the son.

LVI. CASES FROM THE THROAT AND NOSE CLINIC. REPORTED BY DR. J. MARTIN CLARK. STENOSIS FROM MULTIPLE NASAL POLYPI.—*Case 1.* August 24, '97. Chas. M., a Scandinavian, aged forty-four years, by occupation a laborer, says that owing to the asthma for eighteen months he has been unable to work, and for three months past the distress has been so great as to deprive him of sleep. Retiring at 9 o'clock in the evening, he finds no slumber except a very little after four the next morning. When attempting to lie down, severe coughing begins, and upon falling asleep, he is awakened by choking and suffocation. Even sitting up does not prevent this cough at night. At present there is much secretion from the nose and eyes. The sense of smell is lost. He breathes entirely through the mouth. The man looks stupid and discouraged. Says he feels better out of doors. This case has the appearance of hay fever.

Examination of the nasal fossæ anteriorly and posteriorly reveals a complete stenosis of both nares. The uvula and soft palate are relaxed and flabby. The oro-pharynx is spacious, and has enlarged follicles on the posterior wall. Coming down from the naso-pharynx and receding laterally toward the posterior pillars of the fauces, is a deposit of tenacious mucus. With the laryngoscope the same deposit can be seen on the cords and parts adjacent the glottis. After applying a 4 per cent solution of cocaine to the nares the obstruction was diagnosed as mucous polypi.

With the Hovell-Mackenzie snare I at once removed six polypi from the right nasal fossæ and two from the left. The operation produced very little hæmorrhage, and the patient complained of no pain. This so cleared the right naris as to enable him to breathe through the nose. The septum could now be thoroughly examined. The remaining obstruction proved to be caused by a sharp septal deflection into the left inferior meatus, extending the entire length of the cavity, with the addition of a spine upon its prominent angle.

August 31. The patient returned much elated with his condition, saying he had gone to bed that night at eight o'clock and slept soundly until eleven the next day. The

voice had cleared. He breathed easily, and his entire appearance had changed to that of a more normal man. Examining the nares anteriorly, more polypi had dropped into view. I removed six by the same process as at the former sitting. Kali. iod. 2x was given after meals.

Reports of improvement were made every week up to September 27, when Prof. Smith removed the septal spur. The saw was used with good results. By October 12, the mucous membrane had healed and I was enabled by the added space in the left naris to complete the case, removing four large polypi. This patient now breathes naturally through both nares, and although still under observation, he is relieved of his troublesome symptoms and on the way to a permanent cure.

MOUTH-BREATHING WITH HYPERTROPHY OF THE TONSILS.

—*Case 2.* Dr. Clara Hendy, of Oak Park, brought the following case to the clinic :

July 15, 1897. Blanche C., aged ten years. The mother becoming alarmed at the girl's inability to talk plainly, and observing the faulty breathing, claimed there was a growth in the nose, and wished it removed. The girl complains of sore throat every time she has a cold. There is no history of quinsy or diphtheria, but she has had croup a number of times. Upon examination Dr. Hendy found no trouble in the nasal passages, but the tonsils were enlarged, and she advised their removal.

My examination revealed nothing new in the case. The point of interest was the oral breathing. The tonsils were so hypertrophied as to obstruct the ingress of air through the naso-pharynx, thus producing the mouth-breathing. I excised both tonsils, using Mackenzie's tonsillotome. No anæsthetic was given, and the little patient complained of no pain. Dr. Hendy sends word that the child is learning to breathe through the nose. She talks more plainly and her general physical condition is greatly improved.

TONSILAR HYPERTROPHY.—*Case 3.* (18,735). July 13, 1897. Referred by Dr. Ada Morgan. Howard —, aged four years. When two years old he had the measles, which left the tonsils much enlarged. Breathing is always labored and oral, becoming stertorous at night, waking him up at intervals. When asleep he is restless with twitching and jerking of the muscles. Every cold develops into a severe attack of tonsillitis threatening his life. Following

these attacks the tonsils steadily increased in size. His appetite is capricious; he is rapidly losing flesh and becoming mentally dull. Dr. Morgan advised tonsillotomy. I confirmed the doctor's diagnosis and plan of treatment. After applying a 5 per cent solution of cocaine against the tonsils I excised them, using the Mackenzie tonsillotome.

Dr. Morgan writes the results as follows: "Improvement began immediately. He ate a hearty supper of solid food that night without the slightest discomfort. He now sleeps soundly all night, breathes naturally through the nasal passage; has gained flesh, and enjoys his kindergarten work to the utmost. To all appearances he is a perfectly healthy, happy boy.

"The parents think the improvement simply wonderful, as during the past two years not a single month has passed without the child requiring medical attention. I have seen the child but once since the operation, and was quite surprised and pleased at his visible improvement. His throat is normal in appearance."

NASAL STENOSIS FROM ADENOID GROWTHS.—*Case 4* (18,674). April 13, 1897. Helen B., aged thirteen years. For the past three years this girl has been unable to breathe through the nose. Upon close questioning, the mother admits her to have been so afflicted since infancy. She snores constantly when asleep. Owing to the almost entire loss of hearing, she has been taken from school. The ears gather and discharge at intervals.

This patient has the characteristic physiognomy of the mouth breather. Although large for her age and of fair weight, her face looks pinched. The gaping mouth reveals prominent incisors protruding beneath the short upper lip. She is stupid in appearance, but when aroused by a sharp tone of voice talks very intelligently. She claims to interpret to some extent what is said by the movement of the speaker's lips.

Examination shows a contracted oro pharynx and a tendency toward the V-shaped palate. With the rhinoscopic mirror and digital exploration, adenoids were diagnosed. Under chloroform, with Gottstein's curette, the adenoids were thoroughly removed. Owing to faulty respiration, it required fifty minutes' administration of the anæsthetic before the patient became unconscious. She went home the same day, and was given sanguinaria can. 2 every two hours.

Two weeks following the operation a decided improvement in every way was apparent. She could, to a great extent, hear ordinary conversation; at times she breathed naturally, and in appearance was bright and cheerful. She was now placed in the Ear Clinic for treatment.

For three months this patient came weekly to the Nose and Throat Clinic. The nasal respiration improved slowly, as the hard palate was somewhat deformed, elevating the floor of the nares toward the turbinates. The Schneiderian membrane was treated with alkaline and antiseptic solutions, using the anterior and posterior nasal spray points. Following these treatments, applications of the following medicaments were made locally with the cotton-tipped probe, boro-glycerine, and at intervals alternating with

R Tr. iodine..... $\bar{\text{ii}}$
 Potas. iod..... gr. X
 Glycerine..... $\text{ad } \text{qs. } \bar{\text{z}}\text{ii}$
 M.

The child is now well, and able to return to school.

LVII. FOREIGN BODIES IN THE RESPIRATORY PASSAGES. BY DR. ORRIN LELROY SMITH.—*Case 1.* On Thursday, September 9, a tall young fellow of eighteen or so came into the clinic, unable to speak in anything but a scarcely audible whisper, with the following history:

The previous Sunday an acquaintance had puffed in through his open mouth—he was laughing—a so-called “sand” or teasel burr, which instantly rendered phonation impossible and occasioned slight pain; a “pricking feeling” at the level of the thyroid cartilage; and a slight dyspnoëic sense, but no difficulty in drinking or eating. Careful laryngoscopy revealed a white body situated in the anterior commissure, imbedded in, and almost entirely immobilizing, the vocal cords, which were much swollen and infiltrated. The accompanying photograph (See Fig. 16) shows the actual burr imbedded in a roughly schematic and artificial larynx and is very like the pre-operative location excepting that the burr was more on the under side of the cords, which with the ventricular swelling, exposed but a small portion of his burrship.

Somewhat reluctantly, I will admit, the patient was directed to bend well over, inspire deeply and quietly, then to cough forcibly, at the same time sustaining several sharp blows between the shoulders, but to no purpose.

After explaining the dangers incident to such a condition, cocoainization was proceeded with by means of a laryngeal syringe carrying a 10 per cent solution, followed by frequent but very careful brushings with a 20 per cent solution, effecting but unsatisfactory anæsthesia. Alive to the remembrance that the only cases seen that were cocaine proof were Germans, I was not surprised, when in answer to my query, he said "Ya mein Herr," so I decided instantly to waste no more time nor cocaine



FIG. 16. A TEASEL-BURR IN THE LARYNX.

but to proceed even under the imperfect anæsthesia. Passing down the sound it was comparatively easy of course to avoid precipitating the reflex until passing between the swollen cords, where the view was entirely shut off. After several feints in ascertaining distances a warmed and disinfected Schrötter's laryngeal tube forceps was carefully introduced, sent forward, the jaws closed, drawn slightly downward, backward and upward, resulting in a delivery of the burr and immediate relief of the pricking sensation; phonation, however, remaining unchanged,

as had been predicted. The mirror now showed a number of small white indentations in the ventricular bands not unlike stitch hole abscesses. The larynx was immediately painted with boracic acid solution, and bed, light diet, benzoin inhalations and successively arnica, bella-donna and merc. iod. ordered. In less than three weeks he reported an almost normal phonation and but for the fact that yesterday only he contracted a severe "cold" would be here to-night. I might say he has been at work now for three weeks.

The only explanation that can be offered for the peculiar impaction of the body between and on the under aspect of the ventricular bands is that it was first carried into the trachea and then forcibly driven against the slightly tilted cords by the short sharp expiratory blast of air necessary for laughing. While reading over a list of articles extracted from the larynx one would be inclined to believe it difficult to make an addition, yet considerable research fails to bring to light just such a case as I have reported.

Even after months of daily laryngeal practice such cases as these are not altogether easy, nor is it rendered more so by the fact that the subject cocoainizes imperfectly.

Dr. E. M. Bruce, who saw the specimen shortly after removal, says that Germans do not take kindly to anæsthetics of any kind.

Genening voices the sentiment of many operators when he says that in this class of cases, preliminary tracheotomy should be performed, yet it seemed, notwithstanding the imperfect cocainization, that such was not warranted.

Case 2. After the dismissal of sub-class 7, while examining, with Dr. G. O. Denman, of Charleston, Ill., and Dr. Phelps, of Casey, Ill., as guests, the remaining patients, a nervous old colored chap was shown in who said that during dinner the night before there had some cabbage lodged in his throat, since which he had suffered considerable discomfort and some pain on swallowing. We soon found a most uncontrollable tongue, having the arch and persist-

ence of a bucking broncho, intentional aggravation of which on our part induced such retching as brought away three or four recently broken fragments that seemed very like cabbage, giving him professedly relief, yet he was so nervous and excited that his sensations were scarcely creditable.

The faucial pillars were unusually thick and prominent, thus deepening the intercolumnar space, which had undoubtedly proven the receptacle, notwithstanding the elective seat is usually in the lower pharynx in the region of the pyriform sinuses or behind the arytenoid or cricoid cartilages or the epiglottis. Had the offending material been sharp or unresisting we certainly should have been at great pains to proceed more carefully and under cocaine anæsthesia, else it be driven into the retro-pharyngeal tissue necessitating internal, and in some cases external, pharyngotomy, ultimately abscessing or forced downward and so compressing the larynx that a tracheotomy must needs be done.

This particular case illustrates how, in nature's great economy, the very unfortunate and indigent feature that determined the accident and seemingly—but superficially only in truth—frowns down relief measures, very often proves the happy solution of that case which if applied to a somewhat similar one would provoke a calamity; teaching that he who practices empirically commands inferior results compared with him whose professional training and common sense—which I have long believed to be *uncommon* sense—enables him to recognize and go beyond the genus and into the realms of distinctive individualization.

Case 3. Eddy Clipper, æt. eleven. While eating an apple three or four hours ago, something "stuck" in his throat which caused him constant discomfort, rendered swallowing painful and occasioned some slight oppression of breathing, phonation remaining unimpaired, however. Laryngoscopy revealed a foreign substance lodged in the folds of the glosso-epiglottic ligament, which, after the insertion of the mouth gag, was removed by the use of the index finger, proving to be an unusually tough and sharp bit of apple core and relieving him so much that he was at once able to swallow and breathe normally, but naturally enough complained that "it felt as if there was still something

there," but was dismissed with the assurance that everything was removed and that by next day he would be free from that feeling.

The first point emphasized by this case is that not in every such case, by any means, is it necessary to cocaine and instrumentize; that the simpler methods are always preferable, and indeed observation of the methods of the operators whom I most admired, revealed a modern and progressive attempt toward simplicity.

A second point worth more than a passing glance is that many times after a most careful and successful delivery of the foreign substance, a certain amount of after irritation so persists for variable lengths of time that in some instances patients are really inveigled into the belief that there is yet a remnant, and indeed in a small per cent of cases this is so nourished that it blooms into a neurosis.

Apropos of this I am reminded of the case of a London society woman, whose laryngologist had removed a fish bone, who insisted, even after repeated examinations by competent specialists with positive negative results, that at least some portion of the bone and all of the original irritation remained. Finally a young chap dextrously inserted, at the time of his forceps introduction, a small fish bone, which he triumphantly a few minutes later removed, and in two days the patient was well. At the same time he charged her £1,000, and his wife to keep the secret, but once the check was safely banked in Thread-needle Street, somehow or other the truth of the matter finally reached the ears of the doctor's patroness and he was promptly sued. However, the suit was very properly lost, for, as the court decided, the patient was cured. Some two years ago there occurred in my private practice a case very like this one, but unless the patient is considerate enough to die or I get——, the case must go unreported. In nervous or hysterical cases it is certainly not advisable to, day after day, keep up the irritation by examining, even under the express wishes of the patient, but once

having satisfied yourself that nothing remains, to rely upon mucous membrane astringents, galvanism and constitutional measures, not least of which is the banishment of mental and physical idleness. The ordinary post-operative irritation is best allayed by directing the patient to suck and swallow small pieces of ice.

DISCUSSION: Dr. VILAS: In opening the discussion upon the papers presented this evening, I find it difficult to offer any criticism upon subjects so well presented, or upon the work resulting so fortunately.

Before attempting any suggestions additional to those of the several papers, I cannot but congratulate the Society on the results attained in the hospital work as shown by these and the papers of recent meetings. Such skillful work by the several departments was never done in the past as is now being done, so that frequently as has its foundation been tried by unexpected convulsions, we may now believe that naught can permanently cripple the resources of our hospital or destroy its high mission.

The paper by Dr. Forsbeck directs our attention to the value of noting small causes, and the happy results attending on their careful exploration and removal. We are all familiar with the remark of one of England's medical men, that "the practice of medicine consists almost wholly of little things," and "that he who would succeed must not neglect them." How could we have a better exposition of these remarks than in this practical paper?

Dr. Clark's paper opens up subjects of so much import that a more extended time than is at my disposal is needed to consider them all. Generally there is not much difficulty in removing polypi; the difficulty lies in the prevention of their recurrence. I did not hear that the doctor had assured the latter; I think his paper terminated with their removal.

To the treatment of the tonsils we can turn with the assurance of better results, and their excision or amputation in most cases be averted. I have long contended

against the removal of the tonsils (save in exceptional cases) where treatment will be persisted in by the patient, and I am pleased to see that much recent authority is in that direction. Though disputed, I think we may assume that the tonsils were originally placed in the throat for a useful purpose, and there I think we should allow them to remain unless absolutely injurious. Much operating in all surgery is the fad at present; yet I know too well the difficulties of attaining success in dispensary treatment, to long defer relief to such patients as there apply. Delay will not be tolerated by most of these patients, they demanding immediate results. When possible to allow them to remain, however, in public or private practice, I do not advocate the removal of the tonsils before carefully treating them, unless they are the seat of malignant disease. Such internal remedies as the iodides of arsenic, of mercury and of baryta, selected according to constitutional indications, should be given; and if necessary combined with a local mild irritant sufficient to promote absorbent action. Such treatment combined with general bathing, plain or with sea salt, and a carefully regulated diet, will nearly always reduce any enlargement sufficiently to permit the tonsils to remain without causing trouble.

While the exact function of these masses of lymphatic tissue has not been ascertained, sufficient is known to attest their value; and in tuberculous diseases, and those of a similar nature, it is possible there is harm in their removal. The reason I have so often heard for their removal, that "in case the patient should have diphtheria, they would likely prove to be so in the way as to render the case fatal," does not appeal to me. On similar grounds we could clear the way by numerous mutilations for many other disastrous troubles which might or might not attack a patient.

I have dwelt on this part of the report because I have had frequent occasion to give advice on the subject, and after many years' observation of the results of such advice, I cannot but note that the results confirm the advice I have

given. But lest the points be lost, I repeat that nearly all depends on the environment of the patient, that protection may be had from the dangers of taking cold, and that the treatment may be faithfully carried out. Where such can be had, the progress of the patient toward recovery, or the reverse, will be an accurate indication of the thoroughness with which the essential conditions of the ordered treatment are being met.

While all of Dr. Smith's cases are interesting, the first is a notable one, and I congratulate him on the success attained. Had the patient been less well handled, an operation on the trachea would have been necessary. No more in surgery than in war can we reliably estimate the skill displayed by the amount of blood spilled.

It would be difficult to collect a group of more interesting and instructive cases than has been presented here this evening, at the same time displaying the diverse resources of our hospital clinic.

Dr. C. GURNEE FELLOWS : I still remember my first case of foreign body in the throat some twelve or thirteen years ago, when practicing in New Orleans. The patient had some pins in her mouth, when, laughing suddenly, one slipped down into her pharynx, and engaged well down and almost out of sight, having gone down head first. Not having at that time the training acquired in recent years, I simply used my common sense, and pushing the tongue well down by means of a finger of one hand, and inserting a curved forceps with the other, I gradually worked it to the point of the pin and extracted it nicely.

Another case in recent years, which was somewhat peculiar, was as follows : A lady drinking from a glass, bit off a mouthful accidentally, and the annoyance resulting from the splinters in her pharynx, tongue and mouth was great. In such cases it is very difficult to remove all pieces of glass, for they are so difficult to find, and although you should use every available means of inspection directly and with a mirror, you will learn that the sense of touch in such cases helps you more than sight. I

removed all the pieces that could be found, and oddly enough her name was Glass, so that we still had "Glass" to deal with. And right here I am reminded to say that after the removal of foreign bodies by surgical means we often have a *sensation* of the foreign body left there, and the patient still persists that it has not been removed.

It is always a good plan, for the moral effect on the patient, to show him the body that has been removed, for he cannot always be persuaded that it is gone, and it is for just such patients that another variety of treatment is indicated. I refer to our own homœopathic internal medication. The tissues have been lacerated by the foreign body and the efforts to remove it, and it is only natural that a sensation should remain behind, and these sensations are removed by the prescription of internal remedies, notably of *argentum nit.*, or *hepar sulph.*; and I am sure you will find if you have not used them that internal remedies in many such cases are an exceedingly valuable adjunct to the surgical and local treatment.

Another subject that has been alluded to this evening is the necessity for chloroform, and the increase of time necessary in patients suffering with nasal obstruction in order to get them fully under its effects. I do not believe it is entirely because of their nationality, but because so little chloroform is inhaled in one respiration and air with the next that they simply keep see sawing back and forth between consciousness and unconsciousness.

I recently had a case in which the administration of chloroform by Dr. Clark took an hour and a quarter for complete anæsthesia to be induced, and there was a complete obstruction of the nares. When once the obstruction was removed a little chloroform seemed to act very much better than a few moments before in the same patient with the obstructed respiratory tract.

Dr. C. J. SWAN: A fear has arisen in my mind that, influenced by the modest manner in which Dr. Smith has alluded to his case of sand burr in the larynx, the Society may fancy such an operation as he has described to be a

simple matter, the execution easy and the result certain. Such is not my opinion of it. I consider it the most delicate and difficult of all operations upon the throat. I well remember a case which occurred during my assistanceship to Dr. W. A. Dunn upon whose unquestioned skill it is unnecessary for me to enlarge before this society. He made an attempt every day for two weeks before he was able to remove a small fibroid tumor from the left vocal cord.

I have had some similar experiences myself. Of course the difficulty of the operation depends much upon the size, shape and sensitiveness of the patient's larynx, in some cases it being impossible to even introduce a mirror without producing reflex spasms. But even in the most favorable cases the procedure of introducing Schretter's tube forceps and capturing a small body in their infinitesimal jaws requires a high degree of delicacy, tact and skill.

Dr. HASELTINE: The discussion of foreign bodies has brought to my mind a case which came under my observation during my student days, but which, as I was not then especially interested in such cases, I did not have a chance to study closely.

Case. A boy about twelve years of age was chewing the whole grains of wheat as children often do in the country at harvest time, and with the mouth quite full of wheat grains, was seized with a fit of sneezing. He suffered considerable pain at the time, which soon subsided, but shortly after he began to have earache with roaring in the ear and some impairment of hearing on the affected side. The case was neglected with the hope that the child would "outgrow" it and with the result that the hearing of one ear was almost entirely lost. A positive diagnosis was never made, but the history has led me to believe that a foreign body was thrown into the Eustachian tube during the act of sneezing, with resulting salpingitis and stenosis probably complete. If so it was indeed a rare case and one of more than ordinary interest.

Dr. A. K. CRAWFORD: This subject of foreign bodies in the air passages is of more than common interest to me because it is connected directly with the diseases and conditions of the respiratory tract, which has been a special

topic with me in the college and hospital work for many years past.

Case. A somewhat interesting case was sent in from Michigan in the days of the old hospital to obtain relief from a foreign body that the local doctors evidently feared to tackle. The boy had been playing with a large pin, about two and a half inches long, the sharp end of which held a bean. He somehow managed to swallow it "the wrong way" and it dropped through the larynx and found lodgment in the right bronchus. It lay loose there and rattled around, when paroxysms of coughing occurred. Sometimes it would be forced up into the larynx and the resulting spasm would almost strangle him. His mother, who accompanied him, was in dread lest each spasm would prove to be the fatal one. I witnessed one or two of these and they were certainly of such a character that one could but agree with the mother in fearing a fatal issue. The boy would turn blue in the face and struggle violently for a breath of air. No doubt the partial asphyxiation relaxed the laryngeal spasm and allowed the pin to drop back to its temporary home. I recollect well sitting up all night with the lad, scalpel in hand, ready to attempt tracheotomy in case relief did not come to him in this manner. Such a subject apparently warranted the procedure which Dr. Fellows has spoken of as being occasionally admissible. But by good fortune we were relieved from the necessity of resorting to such an extreme course. The boy coughed the pin, bean and all complete, into the upper pharynx, and it was quickly grasped by the attendant. The local broncho-pneumonic inflammation which had been set up subsided in a few days thereafter and the boy went home happier and wiser than when he came.

Dr. Smith's handling of the unique case of the burr lodged in the larynx was a clever piece of work, and deserves unstinted praise. For my part, I am perfectly willing that he should have all such novelties that may come under my notice.

Dr. Clark's cases of tonsillar trouble and extirpation afford me the opportunity to ask these specialists whether there are no dangerous after effects to be feared from the too frequent use of the tonsillotome? I know that a great many doctors, both in the city and throughout the country,

do extirpate these bodies with no other thought than that it is easily performed, and is attended with but little immediate danger.

Case. A young woman in my charge just now has been advised time and again by both laymen and doctors to submit to the removal of her tonsils. Twice this past summer she has suffered from attacks of acute quinsy, each time terminating in suppuration. The normal state of these tonsils seems to be that of chronic follicular inflammation. But there is a very significant family history behind this young woman's throat trouble. Two of her father's sisters suffered in like manner. They had their tonsils removed so as to give them exemption from the frequently recurring attacks of sore throat. In both instances pulmonary tuberculosis set in within a few months of the operations, carrying them to their graves. Now, I do not know what the throat specialists would do in such a case, but I know what I shall do. So long as the patient is under my guidance I will neither remove her tonsils myself, nor allow them to be guillotined by any other doctor. If it is ever done it will be upon the responsibility of some other physician.

Dr. ORRIN L. SMITH: Dr. Forsbeck's concise report of three practical cases recalls a case that my good friend, Dr. Crary, of Kenwood, told me of some time ago over our cigars. When practicing in Wisconsin years ago he was stopped, while driving along a country road, and called in to see a boy that had "something green growing from his nose." One side of the nose, the left I believe, was much distended, and protruding from the corresponding anterior nares were several green shoots. Having nothing along but a pair of artery forceps, the doctor carefully inserted these, open jawed, and brought away a grain of corn, from which the green shoots, had sprung. This serves to illustrate the fact that almost everything has been removed from this portion of the respiratory tract except grains of common sense.

Ordinarily, recent bodies that are not impacted are most satisfactorily removed by directing the patient to close the mouth and by blowing into the unoccluded nos-

trils by a tube or Politzer bag. This failing the careful use of a pair of mouse toothed forceps will often succeed, but if unsuccessful then a snare may be used for crushing. An expedient resorted to this summer in the operative clinic at St. Mary's Hospital, where Mr. Atwood Thorne and myself were at work, in the case of a boy who had slipped into his nose what afterward proved to be a rough, sharp pebble, which had dropped behind a septal spine, making anterior delivery impossible, unless the spine was removed, was to carefully, by means of a blunt probe, push it posteriorly along the floor of the nose until it met and was removed by the index finger, which had previously been introduced into the naso-pharynx. Occasionally from accretions, concretions or adventitious growths succeeding the introduction of the foreign body, Rouges' or Dieffenbach's operation for enlarging the nostril is necessitated.

Not having seen from the first the initial case reported by Dr. Clark, who successfully and ably seconded by the assistance of the interne, Drs. Strawn and Brooks, cared for the clinic during my vacation abroad, I can only testify to the marked improvement from week to week under his care. The spine or spur referred to which I removed at the instance of Dr. Clark, was one of the largest I have ever seen, and revealed the presence of more polypi which the doctor has since removed.

I cannot forbear directing your attention to one point, a point I am sure both Drs. Clark and Morgan warned the patient against, and that is, the ingestion of a meal of solid food so frequently induces troublesome hæmorrhage that the custom of depriving your patient of solid food for four days is quite an established one. An expedient quite worth the while in these nasal obstruction cases that take the anæsthetic slowly is to insert and open the mouth gag early in the administration.

The cases referred to by Dr. Crawford are certainly vitally interesting and I believe it to be an entering wedge that will be driven deeper against indiscriminate tonsilot-

omy and deservedly so. That enlarged tonsils appropriate adenoid discharges that would otherwise cause a laryngeal or bronchial inflammatory soil favorable to tubercular cultivation, or that they may prove a local discharge point is not denied, but that tonsilary abscission precipitates or what seems impossible, causes acute tuberculosis, yet such is the popular, the layman idea of it, an opinion to-day carefully hidden away behind more than one professional waistcoat.

I believe a German's tardy response to the action of anæsthetics to be due to, primarily and secondarily, the immense consumption of beer and tobacco.

LVIII. MÉNIÈRE'S DISEASE. BY DR. CORNELIA S. STETTLER.*—The general practitioner as well as the specialist will be interested in the following quotation from the afore-said clinical lecture:

Prior to the issue of Ménière's original paper this affection passed without recognition. The gastric vertigo, described by Trousseau, attracted almost exclusive attention. Its description by the renowned clinician of the Hotel Dieu rendered it very popular, but now it is almost never met with in practice. Many of the cases described by him as of gastric were really of aural origin. There doubtless is a gastric vertigo, but during the years that I passed in the Salpêtrière, under the direction of M. Charcot, and since that time also, I have never seen a well authenticated case of it.

* * *

If guided by the labors of Ménière and Charcot we so frequently see the vertigo *ab aure laesa* and if, on the contrary, we do not encounter undoubted cases of vertigo *a stomacho laeso*: if one is as frequent as the other is rare, it is true because in Trousseau's time we did not recognize the labyrinthine form of it.

* * *

I believe the gastric vertigo is usually of the same kind that one observes in the neurasthenia of those who have gastric disorders. But how different is the picture from that of Ménière's affection. The vertiginous sensations are much less intense, they never cause a fall, the final vomiting goes by default and the counterfeit is a poor one. The slight vertigo is a part of the conditions only whilst it dominates the morbid scene, when its origin is in the labyrinth. Finally the deafness removes all doubt of the actual conditions.

*Continued from page 545

The *ictus laryngé*, or laryngeal vertigo of tabetic subjects with which the aural variety may be confounded is known by a sudden fall as from syncope, while in good health, a sense of pricking in the larynx, a cough that is short and spasmodic, a stifled feeling and great anxiety of mind. These symptoms may be slight and may soon subside, or they may increase until the patient becomes unconscious, or falls into epileptiform convulsions. But neither the laryngeal onset, the cough, nor the insensibility belong to the aural vertigo. In the laryngeal dizziness there may be dysphonia from a partial paralysis of the laryngeal muscles, so that the loss of voice may be as important a symptom in the one disease as deafness in the other.

The chronic form of labyrinthine vertigo may be confounded with the vertigo from the brain lesions that are associated with syphilis, or leucocythemia; but beside the basilar symptoms that are rarely absent in such cases, there is none of the hissing in the ears that we always have in Ménière's disease. The same is true of dizziness from bulbar lesions and from cerebellar changes. In the latter affections deafness is rare, and the hissing sounds are never present.

While it may happen that this aural vertigo shall occur in an epileptic, the peculiar differences between the syndrome of one and the paroxysms of the other are easily recognized. And the same differentiation is possible between it and the apoplexy of the subjects of arterio-sclerosis in whom there is an absence of the aura in the ear, while the loss of consciousness is permanent; or transient paralysis, persistent headache, swollen features, and the mental symptoms may indicate cerebral softening.

Hysteria sometimes gives rise to symptoms resembling Ménière's disease. There is the characteristic exaggeration of the buzzing in the ears with vertigo, then nausea, and the attack ends with convulsions and a partial or incomplete loss of consciousness. The convulsions may be substituted by laughing or crying, as often happens in hysteria. The ear is not materially involved, or if there is deafness it is slight and transient; while there is a morbid condition of sensibility in the pavilion and in the external auditory canal, and the usual stigmata of hysteria are present.

PART II. *Treatment.* Considering that the causes of this affection are various, it has generally been thought

that the treatment should correspond in this respect. But our author insists that it is not so, if we remember that the indication is to control the hyperexcitability of the labyrinth. The accessory treatment may vary in different cases, but when the diagnosis is established it is practically the same always.

It goes without saying that in labyrinthine vertigo your first care should be to have an aurist decide upon the nature of the lesion that has caused it. If it depends upon the pressure of a hard plug of wax, a very simple operation for its removal may dispose of the vertigo. As for the internal ear, Hillairet long ago observed the cessation of this symptom after the opening of an abscess in the drum cavity. Unfortunately, operative interference is but rarely useful in this locality, even although the lesions are detected. * * * In fact, it is not the acute, but the chronic diseases within the tympanic cavity that are associated with Ménière's disease.

Take for example one of the most frequent causes of this vertigo, sclerosis of the middle ear with ankylosis of the osselets, atrophy of the stapedius and breaking down and rigidity of the oval fenestra. This is a very common condition and if it results in deafness, it happily is not always accompanied by vertigo. But if there is also an excessive excitability of the labyrinth two leading indications will be presented: (1) the sclerosis and (2) the vertiginous reaction. Gellé proposed to perforate the tympanum and to liberate the stapes, but that operation was rarely successful. It is better practice to direct our treatment to the excitable labyrinth, against the effects of which we are properly armed. By this means we avoid increasing the erethism which must be overcome by an operation if there is an obstruction of the Eustachian tube. You can try to reopen it, but you must not forget that sclerosis of the tympanic cavity is often accompanied by that of the tubes. Be cautious, therefore, in your operative interference lest you should increase the difficulty.

Although the endo-lymphatic pressure is so decidedly increased in sclerosis of the renal vessels that the general symptoms of Bright's disease are often present in a slight degree in the aural vertigo, the treatment suited to Bright's disease has no effect upon a genuine case of Ménière's disease. The old use of purgatives, general and local blood letting, leeches, etc., having very properly been abandoned, the manner in which a homœopathic remedy was found is naïvely told:

Matters went on in the old way until 1871, when Charcot interfered. He whom nothing escaped had observed the parallel and the uniform diminution of the hissing sounds, the vertigo, and the abolition of hear-

ing. Finding the treatment hitherto employed insufficient, he asked himself if there was no means of hastening this result, or in other words, if we should not produce deafness voluntarily because it frequently carried off the vertigo with it. Putting this idea, which was altogether empirical, into practice resulted in his discovering a treatment that is a true specific for this affection. Noting the connection between the buzzing and the hissing in the ears and the existence and the exaggeration of the vertigo he thought that by the aid of the sulphate of quinia which, as every one knows, beside other symptoms causes more or less tinnitus and roaring in the ears, one might possibly by giving it long enough, and in sufficient quantity, produce durable changes in the function of the auditory nerve.

Based upon the published experience of Charcot and of his pupils, as well as upon his own extensive observations, our author states his profound conviction that this treatment is almost a specific in true labyrinthine vertigo. It has often succeeded where local and general, medical and surgical treatment has failed. But the technique, as well as the diagnosis, he considers of the utmost importance; no matter how slight the attack, the patient should remain in his room and be placed under the eye of one who will carefully obey the instructions of the physician. If his home surroundings are not suitable, have them changed at once, for the treatment is not pleasant and must be scrupulously applied.

Before undertaking the treatment you must caution the patient that very probably, if not surely, under the influence of the quinine medication he will have an exaggerated vertigo to the point almost of being compelled to keep his bed in order to avoid falling.

It will also be necessary to prescribe a diet as a safeguard, for the sulphate of quinia is inoffensive only to a certain point. You will obtain the best results by substituting milk as the greater part of the alimentation. An exclusive milk diet, however, is not suited to the case unless the syndrome of this peculiar affection is complicated with arterio-sclerosis and Bright's disease. When you institute this regimen you will do well to omit the milk or to give it at long intervals, so as to secure the absorption of the remedy; for the quinine coagulates the milk and interferes with its assimilation.

In what dose should we prescribe the sulphate of quinia? That will vary with the individual susceptibility; for it is with this remedy as it is with the bromide of potassium in epilepsy.

The usual dose is from 7 to 15 grains in the twenty-four hours. A powder may be taken between meals and with water to prevent its disagreeing with the

stomach. Generally at about the second or the third day, the tinnitus and the vertigo increase to the point of becoming unbearable when they will confine the patient to the bed. These effects may persist for eight or ten days. About this time the induced symptoms subside, and in fortunate cases the original ones also; but if the disease is of long standing it is more tenacious and is not so easily cured. Experience shows that in order to avoid an excessive intolerance thereof by the stomach (which would be harmful) this remedy should not be given continuously for more than a fortnight.

If this treatment is properly used it is rare that the worst symptoms of the affection do not yield, but a chronic vertiginous state, with dullness in the head and more or less nausea may remain. Two trials of the remedy at short intervals may be necessary, and even a third one, after waiting a month or two, but the patient should not be lost sight of, for perseverance is the condition of ultimate success. If as usually administered, the quinine causes an eruption or vomiting, 4 or 5 grains may be mixed with the yolk of an egg and thrown into the rectum twice a day. But if the drug cannot be borne either way, Charcot advises the salicylate of soda (which like salicylic acid also will cause a ringing in the ears), of which from two to four grammes may be given during the day for a fortnight, and then withheld for a period. This last remedy has undoubtedly cured some cases, but the quinine is preferable.

If a loss of consciousness is developed and the symptoms become epileptiform, other remedies will be indicated; and so likewise of gout and syphilis. Nothing is said by the author of gelsemium (Ringer), neither of cocaine, causticum, nitro-glycerine, pilocarpine, or the bisulphide of carbon advised by other neurologists in the treatment of this particular form of vertigo.

LIX. FOREIGN BODY IN THE FUNDUS OF THE EYE FOR EIGHT YEARS. BY DR. C. JOSEPH SWAN. *Case.* A. B., laborer, twenty-eight years of age, first came to the clinic in the latter part of July, and complained of excruciating pain in the left eye. In appearance the eye did not differ from the sound organ, but upon closer examination a minute hole was found in the iris at its upper and inner scleral border. After dilating the pupil a careful inspection of the fundus was made with an ophthalmoscope and

at a point directly behind the hole in the iris a black spot in the retina was seen, and in the center of this black spot which looked to be of the size of a pea, there was an elevation three or four mm. in diameter and possibly of the same height. The retina was much congested.

Upon being questioned the patient remembered that *eight* years before while hammering some iron a piece had flown into his eye and was never found; that his eye was somewhat sore for several days afterward, and vision perhaps not quite so good as in the right eye. The incident had been almost forgotten, until recalled by the questions. Treatment was prescribed for the eye and the patient told to report the following Friday. He did not appear, however, until about six weeks had elapsed when he simply wanted to know if I would remove his eye free of charge, as at other clinics they wanted a considerable fee. I examined the eye and found a slight ciliary injection, the vitreous hazy, and the retina, what could be seen of it, intensely inflamed. The patient had been unable to sleep for weeks and looked thin and nervous. The right eye was perfectly normal.

I thought the matter over carefully and decided to enucleate, thus taking as few chances as possible of involvement of the sound eye by sympathetic ophthalmia. Since the operation, two months ago, I have seen the patient three times. In brief, the pain continued for a month after the operation, seeming to be along the course of the facial nerve slightly and deep in the orbit principally, involving, I think, the ciliary nerves.

Finally the pain ceased but two weeks ago he appeared again with a slight retinitis of the remaining eye—what the condition now is it is impossible to say, as I have been unable to secure any regularity of attendance on the part of the patient.

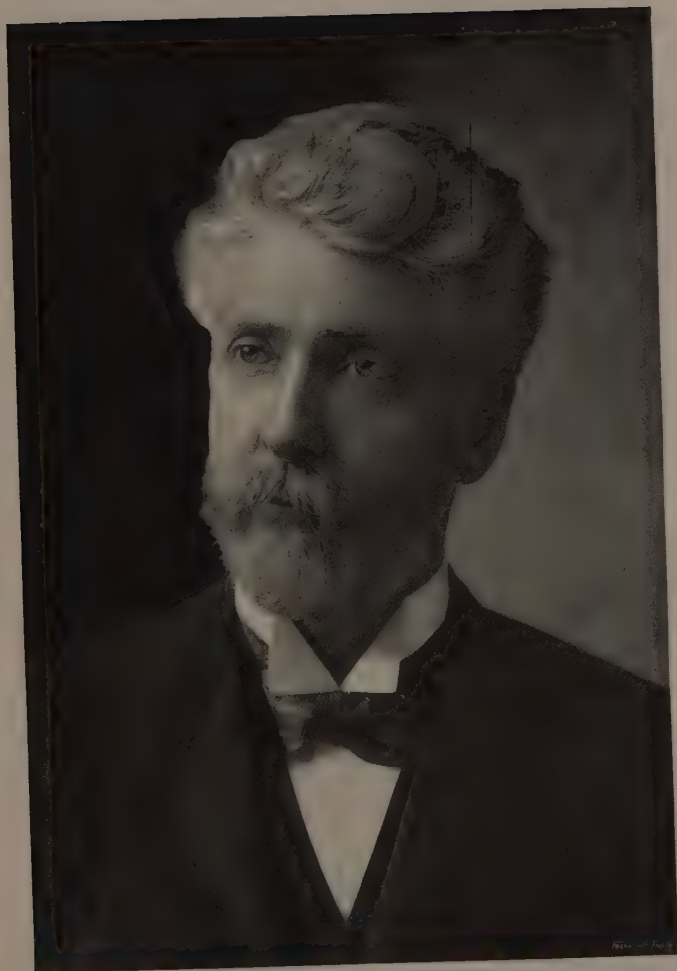
Upon cutting and mounting the specimen the piece of steel or iron was found in the center of a little zone of rust and degenerated choroid and retina sticking in the sclera at the back of the eye. This case presents many unusual features and some that are absolutely unique. Before going into a review of the case I will give here a literal quotation from Dr. Ernest Fuchs, whom I believe to be the greatest living authority upon ophthalmology: "The prognosis must be stated as almost absolutely unfavorable when a foreign body has been left in the eye. A few cases to be sure are known where a foreign body has been carried

about in the eye for years without causing injury. But even in these cases the safety of the eye is to be by no means considered as permanently assured."

So in my case the bit of steel was tolerated for eight years without causing the slightest inconvenience and even then "the safety of the eye was not permanently assured." I have been able to find but one case in ophthalmological literature where the eye has tolerated a foreign body for such a length of time with retention of a very fair degree of vision and without pain or irritation. I believe it to be the only case on record where the foreign body has pierced the cornea and iris and passed to the back of the eye without in any way injuring the lens as was the fact in this case.*

It is extremely unusual for pain to persist in such cases after the removal of the eye, and also is it not only unusual but unheard of for a sympathetic inflammation to begin as a retinitis, or to begin at all after such a lapse of time. There are several explanations which may be offered of these strange phenomena. The most plausible explanation of the retinitis seems to me to be that it was not sympathetic at all but came from causes altogether foreign, possibly syphilis, notwithstanding the fact that the patient denied ever having had the disease. In any case the coincidence is unique. The persistent pain might also have come from a like source, although the presence of the foreign body must have been the exciting cause. Incidentally I may say that the bit of metal when it entered the eye was probably in an entirely aseptic state made so by the heat generated by the blow of the hammer. The irritation finally set up was, I believe, due to the chemical changes taking place in the metal. It is unfortunate that the case cannot be followed to the end. I am inclined to think, however, that the eye must have improved or the patient would have returned. In any event I believe that the report of this case has added something new to the literature of ophthalmology.

* The piece of iron passed through the zonule of Zinn between the lens and the ciliary body.



A. K. CRAWFORD, M. D., SENIOR PROFESSOR OF THE THEORY AND PRACTICE
OF MEDICINE, HAHNEMANN MEDICAL COLLEGE AND
HOSPITAL, CHICAGO, ILL.





Editorial.

CLINICAL DISCUSSION.—The quality of a good clinical discussion is like that of mercy for "it blesseth him that gives and him that takes." It implies that those who participate therein are prepared to state their views clearly and to defend them with a convincing vigor; that they can bring their facts to a focus and then deduct their real meaning; that they have been at the bedside in the capacity of earnest and capable physicians; and that they will be on their guard lest a mere fluency of speech should pass into fluidity and drown their ideas while they are being delivered. Without some such preparation no one can make a practical and adequate talk upon a good clinical paper; and whoever takes the pains to be ready to acquit himself creditably will be the better physician or surgeon for having done so.

Such a discussion also implies the presence of an attentive and appreciative audience. It need not be a large one, and seldom is, but it should consist of those who are endowed with the clinical instinct and appetite, and who are determined to master the resources of our art and to gather up the fragments of a general experience so that nothing shall be lost. When these conditions are met the yield will be a mutual benefit to those who do and to those who do not take an active part in the discussion.

THE OCTOBER MEETING.—The practical character of the work that is done in the Clinical Society, to which we have had frequent occasion to refer, is shown in the report of its last meeting at page 578. In the choice of a theme the Section on duty showed a sense of propriety and good judgment that is not usual among specialists when they bring their reports to a meeting of general practitioners. The lodgment of foreign bodies in the air passages without the power to expel them draws at once upon our sympathies and upon our resources for their removal. The

papers presented are timely and suggestive, and there is a moral certainty that they will be of service in many a troublesome case. It is a pity that a larger number of physicians failed to enjoy the privilege of hearing them discussed by Dr. Vilas and his associates.

The possibility that one who is neither a neurologist nor an aurist may have to treat a case of Ménière's disease, as well as the leanness of our literature upon this subject, invests Dr. Stettler's paper at page 596 with a peculiar interest. And so also does the illustration which it gives of the doctrine of substitution, or supersession, that has so often brought the best of the old school physicians very near to the practice of homœopathy.

HOMEOPATHY AND ANÆSTHESIA.—By a strange oversight the following quotation from Professor Meigs' *Letters to his Class** was not cited by either of the orators, speakers, or writers who participated in the recent Anniversary "doings" over anæsthesia. We publish it with the belated hope that full credit may yet be given to one whose reputation as a teacher, author and practitioner, like that of many another celebrated physician living and dead, was vastly superior to his gift as a prophet.

"It seems to me there must ever be found in human societies a certain percentage of foolish people, who are born to be under the influence of quackery or charlatanism of some sort. You must then expect, as long as you live, to suffer from the annoyance arising out of that class; and you need not expect to subvert or eradicate it when a new quackery breaks forth like homœopathy or anæsthesia."

It was very clever in the late Dr. Oliver Wendell Holmes to coin the word *anæsthesia*, and equally kind in Dr. Meigs to couple it with homœopathy, which latter they both hated to the verge of madness. The irony of fate will link their names with these two forms of quackery as long as the better method of treatment prevails, and while ever "He giveth his beloved sleep."

*4th Edition, Philadelphia, 1850, page 40.

Hospital Notes.

THE SURGICAL CLINIC.

SERVICE OF PROF. HOWARD R. CHISLETT.

TUBERCULOSIS OF THE TESTICLE; CASTRATION; RECOVERY.

—*Case 222.* Mr. C. E. F., aged forty-four, American. This patient has had a varicocele for the last eight or ten years. It has never given him much disturbance except when lifting heavy weights or being for a long time on his feet, when it would give him considerable pain. He had an attack of specific urethritis about eight years ago. The discharge lasted for nearly six months. He gives no history of epididymitis at that time and there is no history of family tuberculosis. His attention was called to the testicle by pain about four weeks ago. Upon examining it he found it considerably swollen and very sensitive even to slight pressure. How long this swelling had been present he did not know nor could he remember any direct injury to the gland. Being a carpenter, however, he may have strained or hurt himself while about his work.

Upon his admission to the hospital the examination revealed the following condition: A large man, rather slender but muscular and of a ruddy, healthy complexion. Digestion good, bowels regular, urine normal. Local examination revealed a very hard, nodular enlargement of the left testicle; very sensitive to pressure and evidence of some fluid in the tunica vaginalis. The spermatic cord was considerably thickened up to within a half an inch of the external ring. The scrotal tissues were not involved. The patient's temperature ranged from one-half to one degree above the normal, the pulse being perfectly regular and not accelerated. Diagnosis, tuberculous orchitis and epididymitis.

Operation. An oblique incision extending from just internal to the spine of the pubis upward and outward over the inguinal canal exposed the spermatic cord below the external ring. The testicle was forced out through this incision, the membranes separated, the cord drawn down and ligated one inch above the noticeable enlargement. The testicle was then removed. A long forcep being passed from the wound to the bottom of the scrotum was used as a guide for making a drainage opening in the base

of the scrotal sac. Through this opening a glass tube was drawn to drain that portion from which the testicle was removed. This being held in place by a suture of silk worm, the upper wound was closed without drainage and a large antiseptic dressing applied. The drainage was removed in forty eight hours, the stitches on the sixth day. Primary union, patient discharged in two weeks.

The removal of the testicle and the operation for varicocele are now commonly done by this incision in the inguinal region, as the testicle can be readily displaced into this incision and the position of the wound renders it so much less apt to become infected.

CARCINOMA OF THE RECTUM; LEFT INGUINAL COLOSTOMY; RECOVERY. — *Case 228.* Mrs. J. H —, (German housewife, aged forty-four. About one year ago this patient suffered a great deal of pain in the rectum. The pain was severe, shooting in character and attended with a dull, heavy aching all through the pelvis. The constipation which had been her habit for many years became gradually worse and for the last three months she has been unable to obtain a bowel movement except by the use of injections and active cathartics. The pain attending the bowel movement has been for the last few weeks excruciating and accompanied by considerable hæmorrhage. The suffering being so extreme and the hæmorrhage at times alarmingly great, the patient had allowed herself to go three or four days at a time without a movement, thus of course making matters worse.

A woman of average size, face pinched with suffering and the body wasted almost to nothing. The local examination revealed a patulous anus from which protruded bunches of hæmorrhoids. Introducing the finger through the anal orifice about an inch and one half it came in contact with a firm, nodular tumor, apparently the size of a fist. Following the canal I was able to find in this apparently solid mass, an opening into the bowel above. The growth was so firmly attached to the surrounding structures that its removal was impossible. Therefore making a diagnosis of carcinoma, I advised an inguinal colostomy as the only means of relief. A catheter was passed through the opening and the bowels flushed as thoroughly as possible before the operation.

Operation. The abdomen being prepared as for any

modern operation, a two inch incision was made parallel to and about two fingers breadth above the outer one-third of Poupart's ligament. The peritoneum being opened, the colon was drawn forward and its mesentery transfixed with a small glass drainage tube. The loop of the intestine thus held in the wound was for greater security sutured to the peritoneum and fascia by several interrupted sutures of fine silk. A large antiseptic dressing was then applied and the patient put to bed in good condition. Forty-eight hours afterward, the loop of intestine was opened by means of the Pacquelin cautery, thus making an artificial anus. No anæsthetic was necessary for this and the relief was immediate. Uninterrupted recovery, patient leaving hospital at the end of the third week.

The condition of the rectum, of course remained unchanged and the operation was simply palliative. The patient, however, lived eight months in comparative comfort.

DOUBLE VAGINAL HYDROCELE; MULTIPLE PUNCTURE; RECOVERY.—*Case 229.* Baby S., aged eleven weeks, of German parentage. Shortly after the birth of this little boy, the mother noticed an enlargement of both sides of the scrotum. This enlargement continued to increase and was regarded by their family physician as double hernia. A careful examination, however, revealed its true nature, a double hydrocele of the tunica vaginalis. The little fellow had also a pronounced phimosis, and recognizing the difficulty of keeping open wounds clean in this locality in babies, I advised circumcision and the evacuation of the hydrocele by multiple puncture with a flat needle. The circumcision being finished, the scrotum was thoroughly cleansed and rendered aseptic, multiple punctures were made into the tunica vaginalis of both sides with a flat Hagedorn needle, thus evacuating the fluid and at the same time irritating the serous membrane. The scrotum was then carefully dressed in iodoform gauze dressing and this in turn sealed by a coating of gutta-percha tissue to prevent soiling by the urine. For the first few weeks after, there was a partial reaccumulation of the fluid, but this gradually absorbed; resulting in a complete cure.

TUBERCULOSIS OF THE KNEE AND ANKLE JOINTS; AMPUTATION; RECOVERY.—*Case 239.* Miss M. S., aged twenty-

eight, German servant. When about nine years of age this girl fell, injuring her left knee. She apparently made a complete recovery. Two years ago she fell again, injuring the same knee and though we could not determine the nature of that injury, we learn that the limb was put in a plaster of Paris cast. After the cast was removed the limb remained powerless and the knee pained her almost constantly. The disease of the ankle joint and foot was apparently secondary to that in the knee, the patient herself believing that the disease extended down from the knee and involved the whole of the lower leg.

A stout German working girl, in good flesh but showing some evidence of hectic. The left leg below the knee was greatly swollen, the knee itself completely ankylosed in flexed position, greatly enlarged and very sensitive to pressure. The ankle joint also was swollen, painful and ridged with sinuses from which exuded a discharge typical of mixed tuberculous and pyogenic infection. Through these sinuses diseased bone could be felt in all directions. The limb being utterly useless and the prospect of patching it up into a useful leg being extremely doubtful, amputation was advised and accepted.

Operation. The amputation was made through the lower third of the thigh; the method adopted being the long anterior and shorter posterior musculo cutaneous flaps. A periosteal flap was then fashioned, and the bone sawed at the point of their reflection. The sutures were then introduced and glass drainage tubes inserted at the lateral angles of the resulting wound. These tubes were removed in forty-eight hours. Result—primary union throughout.

TUBERCULOSIS OF HIP JOINT; FIXATION AND EXTENSION; PRE.—Case 434. H. N., aged four. Two weeks before admission, the boy while playing fell and injured his hip. Since that time he has complained of pain in both hip and knee, and limps when walking. He has had some fever every night since the time of injury. The examination revealed slightly impaired mobility of the right leg, pain upon forcible flexion and inner rotation, temperature 99.3° to 99.5° . The patient was referred to the hospital, the diagnosis being incipient tuberculosis, the probability of its having existed much longer than the parents were aware. The little fellow was put into a box splint extending from below the axilla four inches below the feet,

the foot of the bed being elevated and an extension of four pounds attached to the foot. This weight was gradually increased to six pounds, the patient being kept continuously in bed for four months. During the last four or five weeks of this time his temperature, which had shown an evening exacerbation of from 1° to 1.5° , remained perfectly normal. This was taken as an index that the activity of inflammation had ceased. A Thomas fixation splint was therefore applied, the sole of the opposite shoe elevated one inch, and the patient allowed to go about on crutches. The little fellow was brought to my clinic three months after leaving the hospital, looking perfectly well and with a normal temperature. His father states that "he has had no pain and no fever; in fact, is perfectly well."

THE CLINIC ON GYNÆCOLOGICAL SURGERY.

SERVICE OF PROF. LUDLAM.*

REPORTED BY CORNELIA S. STETTLER, M. D.

GONORRHOËAL OÖPHORO-SALPINGITIS; DOUBLE TUBO OVARIOTOMY; RECOVERY.—Wednesday, November 10. Of the seven laparotomies that I have recently made for serious cause in my department of the hospital, the subjects of which are, I am glad to say, *all* getting well, one was for gonorrhœal lesions of the uterine appendages. The members of sub class 1 present at the operation in her case will recall the serious conditions that were encountered. Here is the pus-sac into which the right ovary was changed, and its corresponding tube. Observe that the tumor is as big as your fist, with a thick wall that is easily torn; that its cavity is lined with a pyögenic membrane, while its external surface shows very plainly its point of attachment to the intestine, from which it had to be separated with great care. This right tube, as you see, is as large as a sausage. The other specimen shows the left ovary and oviduct, for we made a double tubo-ovariotomy. These organs also are badly diseased, but the lesions are more recent than are those of the right appendages.

Now this case represents a state of things that is only too common. A plain, decent, country girl is tempted to drink an exciting liquor that may have been drugged, and then enticed to a single act by which she becomes in-

*Continued from page 557.

fectured with the specific gonorrhœal virus. During the acute stage of the resulting disorder she cannot apply for treatment at home or abroad without a risk of exposure; or if she has treatment it may be worse than none because the doctor is ignorant, or is kept in the dark as to the cause of the mischief. And so the horrible disease spreads and extends until it finds a lodgment in one or both the ovaries and tubes. If the gonorrhœal semen has entered the uterus pregnancy may result. In any event, chronic ill health, an exhaustive leucorrhœa, relapsing peritonitis, a smouldering suppurative fever, multiple abscesses, sterility, and finally, through somebody's prescription, or from sheer desperation, morphinomania with its attendant evils of body and mind, are extremely apt to follow in the train of such an exposure. When our patient entered the hospital she had survived three years of this experience, and by her own confession had been in the habit of taking one-fourth of a grain of morphine every night on retiring.

There are several reasons why gynecological operations upon this class of subjects are troublesome and unpromising. There is a kind of moral dyscrasia, which has its root in wrong doing on the part of the woman, her husband, or her paramour, that leaves its stigma on the mind of the victim, breaking her spirit and destroying the incentive and the desire to get well again. The intemperate habit of using alcohol or morphine, which is the rule in such cases, will have undermined the patient's pluck and resolution. The tendency to adhesive inflammation that binds the appendages to the neighboring viscera, especially to the intestines, as in this case; the formation of fistulous openings into the bowel or the bladder; inveterate constipation, anorexia, a depraved nutrition, and an impaired quality of the blood through the sapping process of a chronic suppuration, are so many obstacles in the way of their recovery. If we add to all these the remote consequences of an infection which made the case a nasty one from the beginning and will often keep it so to the end, you can see why such a woman is very much to be pitied; and why, if we are called upon to treat her at the onset of this vile disorder, we should use our best skill to avert such a calamity as befell the patient from whom these specimens were taken.

In a considerable share of these gonorrhœal cases there is a dash of syphilis, and hence a mixed infection that is very much to be dreaded. When the filthy symptoms of

the acute disorder have been disposed of by treatment, or by limitation, the grave constitutional effects of the latter often crop out and are very difficult of cure.

* * *

Another form of mixed infection occurs in lying-in patients who either during pregnancy or soon after delivery have been poisoned with the gonorrhœal virus; or the woman whose babe is not a month old may suffer a relapse from an ante-partum attack of gonorrhœa that was supposed to have been radically cured. In either case the resulting infection is one of the very worst with which the physician has to contend. Even with the safeguard of aseptic midwifery, which is one of the greatest blessings of the fading century, hundreds of women die each year from this virulent and unsuspected cause.

A bad, but a frequent type of this mixed disorder, is found where conception has unfortunately resulted from an impure coitus and an abortion, early or late, has followed. The direct admission of the virus into the womb, the infection of the endometrium, and the emptying of its contents, whether by accident or design, is very apt to induce this form of puerperal inflammation. Such seizures are the more dangerous because the patient often feels that she cannot go to bed and stay there, so as to be properly treated, and because the doctor is not informed of the mixed source of the mischief.

* * *

Wednesday, November 17. This patient is convalescing safely and surely.

THE PROPRIETY OF HYSTERECTOMY IN CERTAIN NEUROTIC AFFECTIONS.—Wednesday, October 13. In discussing this subject before the general class Prof. L. said: I am privileged to show you two cases that bear upon this very important question. *Case 22,080* is a young woman of twenty-three upon whom I made a double tubo-ovariotomy four years ago for confirmed oöphoro epilepsy. The fits were very severe often ending in coma, worse at the monthly period, but easily induced by excitement, worry or fatigue. The operation was successful in that she recovered promptly, and had no return of the convulsions for several months; but after about a year she gradually relapsed, and of late she has become such a nervous wreck that several physicians and the family insist that the expe-

dient of removing the womb should be tried in the hope of bringing a complete and lasting cure. It is possible that this radical remedy for local irritation of the sexual organs may be the best thing for her, but she is so highly neurotic and the trouble has been so seated and persistent that, although I have promised to make the operation, I am not very sanguine as to the result.

However, this other patient (*Case 17,800*) is a woman whose case was the text of a lecture in this clinic in 1886, and upon whom I made a vaginal hysterectomy before a sub-class, June 12, 1889.* She had been an invalid for more than twenty years, or since the birth of her only child. The menses became irregular and the pain in the ovarian region so severe that only morphine would control it. Spasms and convulsions grew more and more frequent and severe, until she sometimes had as many as ten in a day. The hysterogenic zones were very pronounced and once I induced a fit at will before the class by pressure upon them after the manner of Charcot. The paroxysms could also be arrested in any stage of their progress by pressure upon the ovarian zones especially. In May, 1888, I made an unsuccessful attempt at the removal of the ovaries, but because of the extraordinary adhesions was obliged to relinquish it. As far as possible, however, those organs were liberated, and for some months she had no more fits, and was generally improved; but after that the old trouble returned with increased severity. Finally, in 1889, she insisted that the uterus must be taken out or she never would get well. It was done and she made a good recovery. The only striking incident connected with her convalescence was that on the sixth day, when her menses were due, her temperature mounted to 106.5° , and on the seventh day to 109° . All the facts connected therewith are authentic and may be found in volume X., of the CLINIQUE. From that time until now, or almost *eight and one-half years*, she has never had another spasm, nor been ill in any way, is an active and useful member of her family and of society, not being an invalid any longer.

This second case certainly affords good ground for the belief that the removal of the uterus offers hope for a cure in certain neurotic affections. It will not cure them all, nor even, perhaps, a considerable share of them, but it is a resource that promises much in the cases to which it

*The CLINIQUE, Volume VII, 1886, p. 446, and Volume X, 1889, p. 270.

is adapted. If it shall have as good an effect upon our young patient here upon the table as it did upon the one who sits before you clothed and in her right mind, we shall be justified in having resorted to so radical an expedient.

October 19, a vaginal hysterectomy was made for case 22,080 before a sub-class, and the uterus carefully and successfully taken.

November 10. Her convalescence has been prompt and perfect, and thus far there have been no more spasms.

CLINICAL CHIPS.—In an emergency case a newly washed nightshirt makes a good operating gown.—For post-operative occlusion of the bowel, especially after vaginal hysterectomy, experience proves that it is safer to make an artificial anus (that will heal spontaneously) than to do a laparotomy.—The continuous galvanic current is useful in some cases of Basedow's disease, but it will not cause complete resolution of the thyroid tumor.—One of the best remedies for chronic constipation, especially in chloro-anæmic women with dyspepsia, is to give seven or eight drops of pure creosote twice a day in a glass of milk, beer, or wine and water.—Apomorphine is contraindicated in heart affections.—According to Jaccoud the same is true of the salicylates in rheumatism involving the heart or the lungs.—A quick and ready method of rendering a metallic sound aseptic is to dip it in alcohol and set fire to it.—Canova claims that injections of a one per cent solution of ichthyol is the best treatment for gonorrhœa in women.—Jonnesco, of Bucharest, reports three cases in which a bilateral section of the cervical sympathetic, the same as for exophthalmic goitre and epilepsy, has been of the greatest service in glaucoma; indeed, in one case it cured total blindness.—Hypodermic injections of the bichloride and ice-bags to the head cured 19 out of 27 cases of cerebro-spinal meningitis. (Angyan.)—*On dit* that the best local application in sciatica is pure chlorohydric acid on layers of cotton and covered with a loose bandage.

Miscellaneous Items.

The Section on Obstetrics, Dr. Sarah Hobson, Chairman, will present the following papers at the next meeting of the Clinical Society, November 27: *False Prophecies in Obstetrics*, by Dr. C. S. Stettler; *Remedies During Labor*, by Dr. G. Hardy Clark; *Pelvic Measurements Previous to Delivery*, Drs. Leavitt and Honberger; and *The Obstetrician's Obligation to the Gynecologist*, by Dr. Sarah Hobson.—The Hahnemann Hospital has more patients than ever before and the white gowned sub classes are as busy as nailers in going from one clinic to another.—Our list of marriages includes that of Dr. Peter Nelson, of St. Paul, to Miss Alice Keefer; Dr. J. Norman Davies, of Warren, Pa., to Miss Alice Maude Brennan; and Dr. C. W. Baird, of Beatrice, Neb., to Miss L. Virginia Gates, to whom our hearty congratulations are extended.—The ladies of Buffalo, with a most commendable spirit, have formed a Hahnemann Monument Association in aid of the fund for the completion of the proposed monument to the master. The project is a good one and is bound to succeed. Letters and contributions may be addressed to Mrs. A. R. Wright, Treasurer, 414 Elmwood Avenue, Buffalo, N. Y. Removals: Drs. Ada E. Bishop from St. Marcial, N. M., to El Paso, Texas; S. C. Whitcomb, from Oneida to Farmington, Ill.; A. E. Carr, from Grand Island to Lincoln, Neb.; A. C. Tenney, from Spencer to Mt. Vernon, Iowa; and Dr. Lila E. Beers, to Morgan Park, Ill.—Dr. Wm. Stolz will spend the coming year at Königstein, Germany.—Dr. E. P. Crockett, Hahnemann '95, died recently at Phoenix, Arizona, of pulmonary tuberculosis.—The earnings of the hospital ambulance for this year, contributed by Boydston, Bros., will exceed \$200.—Whoever was told that the veteran Talbot had gone to the *Bad* (in Germany) will be pleased to learn of his recovery and of his safe return to Boston.—Prof. Crawford's friends will be glad to find his portrait in this issue.—Prof. Arnulphy has promised our readers a paper on the risk involved in removing the tonsils of tuberculous subjects.—The *Medical Century* very properly endorses Prof. Shears as a first-class surgeon.